MENTAL HEALTH

STATEMENT OF PURPOSE:

School health services shall be a part of a comprehensive approach to caring for students with mental health issues.

AUTHORIZATION/LEGAL REFERENCE:

- 16 V.S.A. Chapter 99 § 2902 - Education support system
- 33 V.S.A. Chapter 43 § 4305 – Coordinated system of care

DEFINITION:

Mental health issues and illness of children and youth may include:

- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Anxiety Disorders
- Mood Disorders
- Suicide attempts
- Eating Disorders
- Substance Abuse
- Aggressive, disruptive or violent tendencies
- Conflicts regarding sexual identity
- Self-harm cutting
- Post traumatic stress disorder
- Obsessive-compulsive Disorder
- Oppositional Deficit Disorder

SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

Act as a resource for:

1. Assessment, intervention and follow-up of students, as well as for identifying existing and emerging mental health needs that affect school success.
2. The educational support team and crisis intervention teams.
3. Health care providers and family to optimize treatment plans.

RESOURCES:

- AAP Mental Health in Schools Statement - http://aappolicy.aappublications.org/cgi/reprint/pediatrics;113/6/1839.pdf
- Achenbach Child Behavior Checklist for Ages 6-18 and Teacher's Reporting Form for Ages 6-18
- Children and Adults with Attention-Deficit (CHADD) /Hyperactivity Disorder - www.chadd.org
- Connors' Teacher Rating Scale and Parent Rating Scale

- Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington D.C., 1994
- National Association of School Nurses (NASN) - www.nasn.org
- National Mental Health Association (NMHA) - www.nmha.org

SAMPLE POLICIES, PROCEDURES AND FORMS

Vermont Multidisciplinary Approach to the Assessment and Treatment of School Aged Children with Symptoms of Attention Deficit Hyperactivity Disorder

Vermont Multidisciplinary Approach to the Assessment and Treatment of School-Aged Children with Symptoms of Attention Deficit Hyperactivity Disorder

Families, Educators, Physicians and other Professionals Working Together on Behalf of the Child

Introduction:

In March 2003, the Vermont Department of Health (VDH) and Vermont Child Health Improvement Program (VCHIP) convened a summit meeting on Attention Deficit Hyperactivity Disorder (ADHD). The objective was to discuss the topic of ADHD especially as it applies to Vermont children and to consider adopting the ADHD Toolkit, developed and copyrighted in 2002 by a joint venture of the American Academy of Pediatrics (AAP), National Initiative for Children's Healthcare Quality (NICHQ) and McNeil Pharmaceuticals, as the Vermont ADHD assessment standard. At the conclusion of that meeting, it was clear that participants were not ready to adopt the NICHQ Toolkit without further consideration. There was consensus, however, that it would be desirable to have a standardized approach to how we assess, and treat Vermont school-aged children with symptoms of ADHD.
Subsequently, a working group comprised of 25 individuals representing 12 domains including: Department of Education (DOE), Vermont Department of Health (VDH), Department of Developmental and Mental Health Services (DDMHS), VCHIP, Parent to Parent, Vermont Parent Information Center (VPIC), parents, special educators, school psychologists, psychiatrists, pediatricians, and neurophysiologists met three times. The group agreed with the basic premise: the desirability of having a standardized approach to the assessment, and treatment of school-aged children with symptoms of ADHD. Furthermore, it was considered critical that families, educators and medical professionals work collaboratively to develop this system.

The products of the ADHD working group include:

- a *detailed* flow chart which maps the multi-disciplinary approach to the assessment and treatment of school-aged children with symptoms of ADHD
- an *abbreviated* flow chart which is a simplified version of the detailed flow chart
- an *educational* narrative which describes more specifically the educational components involved in the detailed ADHD flow chart (right hand column in green)
- a *medical* narrative which describes more specifically the medical components involved in the detailed ADHD flow chart (left hand column in blue)
- a *family/caregiver* narrative which describes in detail the family/caregiver components of the detailed ADHD flow chart (central column in yellow)

The products of the working group are described in the following narratives. Please refer to the three separate narratives, medical, educational and family/caregiver, for a comprehensive description of the attached ADHD flow charts.

The **title** was developed to clearly state the intent and importance that this work be collaborative in nature. It is meant to foster a sense of partnership between families, educators, medical and other professionals in the assessment of school-aged children with symptoms of ADHD. It is our hope, that in the future, a similar flow chart will be developed for preschool-aged children with symptoms of ADHD.

The **asterisk [*]** alerts the reader to the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM IV™) classification of ADHD into three (3) subtypes: Predominantly Inattentive Type,

Hyperactive – Impulsive Type, and Combined Type. Previous nomenclature such as Attention Deficit Disorder (ADD), Hyperactivity Disorder, etc, is subsumed in the current classification.

The boxes are **numbered** purely for ease of reference. Numbering does not imply importance, nor does it indicate a rigid sequence. For example, Box 2 does not necessarily come before Box 3 or Box 4.

The **arrows** depict lines of communication that are essential in understanding and using the flow charts.

Medical Narrative

BOX 1. *INITIAL ASSESSMENT TRIGGERED BY*: An initial assessment can be triggered by concerns in any or all (or any combination) of 5 areas: distractibility, impulsivity, hyperactivity, behavioral or social problems or academic underachievement. Concerns may arise from any source, however, the family / caregiver, school personnel or medical professionals are the usual sources.

BOX 3. *INITIAL MEDICAL CONSULTATION:** The asterisk [*] indicates that this consultation usually requires more than one interaction.

- The pediatric Primary Care Provider (PCP) should explain the assessment and evaluation process for students with symptoms of ADHD.
- Tools that can be used include the *detailed* flow chart, the *abbreviated* flow chart or any other instrument that conveys similar information.
- At the initial visit, it is appropriate to begin to implement Box 4: "Beginning of Dialogue about Advocacy, Collaboration and Information Sharing Between Family / Caregiver and School, Healthcare Provider, and / or Others.**"** A discussion of the importance of working together as a team is often helpful in setting a positive tone. It is important to be aware that not every family will be ready for this kind of sharing initially. A written consent form must be obtained when information sharing is desired.
- The primary care provider obtains a medical history and full "review of systems" (ROS). This provides detailed medical background information that is pertinent to the evaluation. The ROS includes information about the child's birth, development, temperament, medications, allergies, family and social history, and a systematic review of each body system (e.g. central nervous system, respiratory, cardiac, gastrointestinal, etc.).
- Parent and School Information: The VT ADHD working group recommends use of a DSM IV™ based tool for the diagnosis of ADHD *combined with* an instrument which identifies the presence of a broad range of symptoms. This will assist PCPs in screening children for co-morbid conditions.

Tools specifically designed to detect the DSM IV™ criteria for ADHD:

ADHD Rating Scale IV. This instrument closely approximates symptom criteria for ADHD. Parent and teacher versions provide a brief (18 item) checklist of symptoms. Analysis of symptoms by age and gender provides developmentally sensitive cut-off scores that make this instrument appropriate for screening and diagnostic assessment. Caution should be used with African American children and using this scale for treatment monitoring. The booklet must be purchased and entitles the user to make as many copies as desired. [ISBN 1-57230-423-5]

Conners' Rating Scale-Revised. This scale has parent, teacher and adolescent questionnaires in Long Form (59-87 item) and Short Form (27-28 item) versions. These well-validated questionnaires do not mirror symptom criteria for ADHD but have other benefits. The Long Form is a useful diagnostic assessment instrument that taps a broad range of emotional disorders. The Short Form is a good screening instrument that is sensitive to treatment effects and can be used for monitoring.

ADHD Symptom Checklist-4. This checklist closely approximates symptom criteria for ADHD and ODD with additional items on aggression and a checklist of stimulant side-effects. Parent and Teacher Forms (50 item) can be recommended for screening purposes and are highly recommended for monitoring treatment effects, especially stimulant medication.

NICHQ Vanderbilt Assessment Scale Parent and Teacher Informant (initial assessment and follow-up assessment). This assessment scale provides Parent (55-item) and Teacher (43-items) measures of symptoms of ADHD, common co-morbid conditions (Oppositional Defiant Disorder, Conduct Disorder, Anxiety and Depression), and broad measures of functioning. A more brief follow-up form monitors ADHD symptoms, academic performance and common medication side effects. The Vanderbilt Assessment Scale is available free at the NICHQ website. These forms are NOT normed for age or gender and evidence of its' discriminate validity is insufficient.

It is recommended that all ADHD checklists be validated instruments, based on an assessment of the DSM-IV™ criteria for ADHD.

In addition to assessing ADHD symptoms, it is essential to screen for possible symptoms of co-morbid conditions. We recommend using an instrument such as the Achenbach Child Behavior Checklist which screens for a broad range of symptoms.

The **Achenbach Child Behavior Checklist (CBCL)** is an empirically derived instrument normed for age and gender. This instrument can be used over time to assess changes in symptom presentation. There are Parent and Caregiver/Teacher Forms for children age 18 months to adult. Youth Self-Report Forms are available for age 11 to adult. The CBCL is well validated and widely used nationally and internationally. It is available in a paper version and as a web-based system.

If suspicion of co-morbid conditions is raised, the PCP can refer to the ADHD Resource List (attached).

- Information from school: It is vital to have accurate information from school. It provides an opportunity to highlight the student's strengths, and provides documentation about behaviors which interfere with function in the school setting. This ensures that co-morbid conditions such as learning disability, anxiety, depression etc. will be considered from the outset. The school psychologist may be involved in this process as well.

- Information from school regarding student strengths, school history, academic profile, behavioral and academic concerns, educational strategies, modifications and accommodations already provided or tried, etc. can be obtained from school using the instruments entitled: Student Information Form (Grades K-6) and Student Information Form (Grade 7-12).

BOX 8. ***FOLLOW-UP MEDICAL VISIT:*** Following review of all the above, it is essential to meet with the family again to discuss the findings and develop an appropriate treatment plan.

- If the student meets the criteria for ADHD, advance to Box 9.

BOX 9. ***DEVELOPMENT OF A MULTIMODAL ADHD TREATMENT PLAN:*** Discussion and development of a multimodal ADHD treatment plan includes:

- Child/family/caregiver education: Education regarding ADHD promotes understanding, patience and empathy as well as offering an opportunity to develop creative, family-specific strategies for success. Individuals might consider the Vermont Parent Information Center (VPIC) and/or Parent

to Parent of Vermont (See ADHD Resource List) for additional information and support for families/caregivers.

- Instructional modifications, accommodations and supports in school and at home: This may be informal or involve a specific 504 Plan or an Individualized Educational Program (IEP) through the services of the Special Education Department.
- Behavioral treatment: This may involve developing/maximizing the child's coping strategies, personal strengths, addressing social skills issues, time management and organizational skills, strategies for dealing with frustration, anxiety, feeling overwhelmed etc.
- Family/caregiver and or child counseling: Individual and/or family counseling can be helpful in addressing behavioral issues, parent/child conflicts, socia l skills issues, anxiety management strategies, parenting difficulties etc.
- Medication: Research has clearly demonstrated that medication can be very helpful in treating the core symptoms of ADHD: inattention, impulsivity and hyperactivity. The PCP needs to schedule regular medication monitoring visits with the child and family and have ongoing communication/collaboration with school personnel. This is necessary to assess the benefits and possible side effects of medication treatment.
- Parents, school personnel and the PCP should collaborate in order to identify ADHD target symptoms and develop an individualized ADHD treatment plan.
- When indicated, the PCP should provide a summary letter for school regarding the treatment plan proposed.

- If the student does NOT meet the criteria for ADHD, but meets criteria for another diagnosis, advance to Box 14**.**

BOX 14. ***DEVELOPMENT OF APPROPRIATE TREATMENT PLAN:*** Develop an appropriate treatment plan for that condition.

- If the student does NOT meet the criteria for ADHD or another disorder, advance to Box 13.

BOX 13. ***ONGOING EVALUATION OF CHILD'S*** **Function, Symptoms, Strengths, Response to treatment**: Pursue ongoing monitoring.

BOX 5. ***ONGOING ADVOCACY, COLLABORATION AND INFORMATION SHARING WITH FAMILY / CAREGIVER:*** This communication should take place regularly during the evaluation process and follow up.

BOX 11. ***FAMILY/CAREGIVER ARE AWARE OF AND INVOLVED IN TREATMENT PLANS:*** Treatment plans should be constructed using all available information. Plans should utilize and maximize the student's personal strengths. Plans should be a collaborative effort of all parties.

Family/Caregiver Narrative

BOX 1. ***INITIAL ASSESSMENT TRIGGERED BY:*** This box lists the types of concerns that would prompt a parent or caregiver, school personnel, or physician to seek further assessment for the child. If families/caregivers are the first ones to have concerns about the child, a good first step is to bring these concerns to the classroom teacher or other school personnel and the child's health care provider. As noted in the educational narrative for Box 6, if a parent/caregiver or teacher believes the child has a disability and is in need of special education, the parent may make a direct referral to the special education administrator at any point in the process.

BOX 4. ***BEGINNING OF DIALOGUE ABOUT ADVOCACY, COLLABORATION, AND INFORMATION SHARING AMONG FAMILY/CAREGIVER, SCHOOL, HEALTHCARE PROVIDER AND/OR OTHERS:*** It is important for all parties involved in the assessment of a child who has symptoms of ADHD to recognize that a high quality, comprehensive assessment is a process. This process requires collecting and analyzing a wide range of information to make an accurate diagnosis. The Vermont Department of Education recognizes that psychologists and physicians can make the diagnosis of ADHD in order to provide appropriate school services. The medical diagnosis of ADHD is usually made by a physician. All of these professionals use a standard set of criteria contained in the contained in the Diagnostic Statistical Manual (DSM-IV) to make the diagnosis. These criteria assess whether the child has significant difficulties with distractibility, impulsivity, and hyperactivity. Additionally, the difficulties must represent a significant, longstanding impairment in functioning in two or more settings.

Families/caregivers come to the assessment process at different stages of readiness to share information about their child and family. There are many reasons why families/caregivers might hesitate to share information about their child. Some families/caregivers fear an assessment for ADHD means the child will be "labeled" and automatically prescribed medication. Families/caregivers may also feel certain information is too sensitive to share and feel their privacy is threatened. They may also wonder why such information is necessary to share during the assessment. Professionals involved with the assessment process should exercise sensitivity regarding family/caregiver concerns.

The Vermont Parent Information Center (VPIC) has developed two fact sheets, "How Families and Professionals Can Build Winning Partnerships" and "How Parents Can Communicate Effectively with Professionals". These handouts (attached) offer suggestions for families/caregivers and professionals on ways to develop a productive working relationship on behalf of the child.

In order for health care providers, school and other professionals involved in the assessment to share information about the child with each other, a written consent from the child's family/caregiver, specifying the types of information to be shared, is required.

Families/caregivers are the experts when it comes to their own children. The bulleted items in this box list some types of information families/caregivers can expect to be asked to share with the primary health care provider, school personnel or the school psychologist, in the course of an assessment for ADHD.

- Families'/caregivers' (and child's, when appropriate) concerns, goals, and ideas
- Child's strengths and interests
- Family make-up (such as other siblings, children adopted; parents married, single, divorced, widowed, etc)

- Prenatal and birth history (such as information about the length of the pregnancy, any complications with the child's birth)
- Child's development (such as language development, when the child walked) and
- temperament (such as "easygoing" or "slow to warm up")
- Child's medical history (such as significant illnesses, hospitalizations, surgeries, substance abuse)
- Extended family history (such as medical history, history of school or learning problems, substance abuse)
- Family stressors and/or traumas (such as a recent move, the death of a loved one or other loss, substance abuse, an accident or serious injury, or stressful home environment).
- Child's school performance, past and present
- What has been tried to support the child? (this can include things that have been tried at home, in school or other settings)
- What works and what does not work for the child? (What types of environments or activities does the child do best with and what types of environments or activities are challenging for the child?

The primary care provider may already have valuable information such as prenatal and birth history, medical and developmental history. Families/caregivers may be asked to complete a form with some of the information noted above prior to an appointment.

BOX 5. ***ONGOING ADVOCACY, COLLABORATION AND INFORMATION SHARING WITH FAMILY/ CAREGIVER*****:** Families/caregivers also have an important role as their child's advocate. An advocate looks out for the child's interest and makes sure the child gets an appropriate assessment and services. The VPIC handout "Advocating for Your Child" provides a brief introduction to help families/caregivers advocate for their child. Family/caregivers might also consider contacting VPIC (See the ADHD Resource List for contact information) for more information and support in advocating for their child. Parent to Parent of Vermont (See ADHD Resource List for contact information), is another statewide organization that helps families/caregivers of children with special needs find support from other parents, healthcare professionals and the community.

BOX 11. ***FAMILY/CAREGIVER IS AWARE OF AND INVOLVED IN TREATMENT PLANS*****:** If a diagnosis of ADHD has been made, a treatment plan needs to be developed. Families/caregivers (and child, if appropriate) school staff, and the primary care provider should all participate in the development of this plan. The treatment plan should meet the child's and the family/caregiver's concerns and needs and take advantage of the child's strengths, interests, learning style, temperament, and developmental level. If medication is part of the treatment plan, it must be prescribed and monitored by a medical professional licensed to dispense medications. The treatment plan should also include regular exchanges of information between families/caregivers and other team members. If the child is found eligible for special education, the family/caregiver has rights that ensure a regular exchange of information between the family/caregiver and the school.

For instance, the family/caregiver must be invited to participate in the development of an Individualized Education Program (IEP), which is a written plan for a child that describes the special education and related services a child will receive if eligible for special education. Families/caregivers will receive notification of all meetings for this IEP development. Based on the federal Individuals with Disabilities Education Act (IDEA) and the Vermont Department of Education's Special Education Regulations, families/ caregivers can expect to receive information

from the school that describes their rights in special education. The Vermont Parent Information Center (VPIC) offers two helpful fact sheets entitled “Parents’ Rights in Special Education” and “The Individualized Education Program (IEP)” which are attached.

For children determined to have a disability, but who are not eligible for special education services, they may be found eligible for accommodations and/or services under Section 504 of the Rehabilitation Act. Families/ caregivers are also part of the development of the 504 Plan. Families can still benefit from learning about how to advocate for being included as a regular member of the team and in the exchange of information. This will serve to update information collected during the assessment and to help determine the child’s response to the various interventions and/or changes in other areas that might affect this response. The VPIC fact sheet “What You Need to Know About Section 504” (attached) is a helpful resource on Section 504.

Educational Narrative

BOX 2. ***INITIAL EDUCATIONAL INTERVENTIONS*****:** At any point, as a student experiences difficulties with any of the five symptoms of ADHD (distractibility, impulsivity, hyperactivity, behavioral or social problems, or academic underachievement) in the classroom setting, it is expected that the classroom teacher would provide interventions specially designed to meet the needs of the student. To accomplish this, all classroom teachers need training on providing accommodations and modifications to classroom routines for students with intentional problems. Included in these accommodations and modifications will be communication with families/caregivers and school staff with particular expertise in this area. If the teachers' accommodations or modifications do not adequately address the student's needs, the teacher will then refer to the Educational Support Team (EST).

BOX 6. ***REFERRAL TO EDUCATIONAL SUPPORT TEAM (EST):*** The EST exists in each school and consists of a variety of school staff (administrator, school counselor, behavior specialist, nurse, special educator, classroom teachers) that meet regularly to discuss student needs and help create plans for students at risk. Many students with attentional issues are likely to be referred to this team for help from teachers and support staff in understanding and planning to meet the student's needs.

- Planning at this level requires data collection and, minimally, informal evaluation of student's learning profile. Included in EST plans are designs for further data gathering as well as immediate interventions. If, over time, these interventions do not result in improved performance, this team may consider a referral for a special education evaluation. This referral is made if there is reason to believe that the student is disabled and in need of special education.

Note: If a parent/caregiver or teacher believes the child has a disability and is in need of special education, the parent may make a direct referral to the special education administrator.

BOX 7. ***REASON TO BELIEVE THAT STUDENT IS DISABLED AND IN NEED OF SPECIAL EDUCATION*****:** The special education evaluation process is clearly defined by state and federal regulations. The evaluation and planning process is accomplished in two basic steps.

With family/caregiver participation, a plan for comprehensive evaluation is designed to identify areas of concern and outline evaluation procedures for determining the student's skills and challenges in each identified area as they relate to the educational environment. These areas include the basic academic skills in reading, math and writing, and motor skills. Once parental consent is obtained, the evaluation will be conducted within 60 days. For students with suspected ADHD, a physician, and when appropriate, a school psychologist, should play an active role. A student is determined to be eligible for special education if the team identifies an adverse effect on acquisition of basic academic skills.

A student's eligibility for special education is based on the following:

1. The presence of a disability
2. If there is a disability, whether it has an adverse effect on educational performance in one or more of the basic skill areas, and if 1 and 2 are present,
3. Whether the student needs special education services to benefit from his or her educational program and that this support cannot be provided through the educational support system, standard instructional conditions or supplementary aids and services provided in the school.

- If a student is found eligible for special education, an individualized educational program (IEP) is written by the team. This plan details the student's present levels of performance, annual goals and objectives to meet the student's learning needs, and special education services to be provided by the school. The IEP is updated annually and a reevaluation of special education eligibility occurs at least once every three years.

If the student is found not eligible, the team will provide recommendations to the classroom teacher and parent/caregiver for continued interventions.

BOX 10. ***IMPLEMENTATION OF IEP OR 504 PLAN:*** For students eligible for special education, the IEP is implemented. Ongoing assessment of identified educational goals informs the team as well as other health care professionals involved in related aspects of the student's life. This may include the family physician or other medical professionals.

- Occasionally, students are not determined to be eligible for special education even though they have been diagnosed with ADHD. For these students, accommodations that will provide equal access to school activities are usually outlined in a plan format as described in The Vermont DOE booklet *Section 504 of the Rehabilitation Act of 1973 and Vermont Schools* (11/2002), which includes a section on ADHD.

BOX 12. ***ONGOING COLLABORATION AND MONITORING OF STUDENT PROGRESS*****:** At any of the previous levels of intervention, appropriate school personnel are available to interact with family and medical personnel in order to provide ongoing monitoring of student progress. The lead individual for the school may be any of the following:

- Classroom teacher
- Building administrator
- Educational support team coordinator
- School guidance personnel
- Nurse
- Special education case manager
- Section 504 case manager